STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) Office of Health Care Assurance (OHCA) conducted a recertification survey from 02/02/21 through 02/08/21. The SA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #8675, #8373, #8422, #8338, #8264. Complaint #8675 was found substantiated. Complaint #8373, #8422, #8338, #8264 were found to be unsubstantiated. At the time of entrance, the census was 88.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		3/18/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 1 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 2 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure there was documentation that a resident's notice of transfer and discharge to a hospital, including the reasons for the resident's discharge was in the clinical record. In addition, the facility failed to send the notice in writing, to the	F 623	1.R35□s representative was notified of R35□s discharge on 12/30/20. There was no adverse outcome. 2.Residents discharging from the facility have the potential to be affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 3 resident's representative in a language and manner they would understand, and to the representative of the Office of the State Long-Term Care (LTC) Ombudsman, for 1 of 18 residents (Resident (R) 35) selected for review. This deficient practice had the potential to affect any resident being transferred or discharged from the facility. Findings Include: R35 was discharged from the facility on 12/30/20 as a result of an acute condition he suffered. R35 was transferred to an acute hospital and admitted for a stroke he suffered. Subsequently, R35 was discharged from the hospital and re-admitted back to the facility on 01/02/21. During an interview with R35's representative family member (FM) on 02/04/21 at 12:10 PM, the FM confirmed that R35 was taken to an acute hospital for a "mini stroke" at the end of 2020, then returned to the facility and received skilled rehabilitation services. Record review (RR) however, revealed there was no clinical documentation that R35's FM received notice of R35's discharge in writing, and the reasons for his discharge on 12/30/20. There also was no documentation that the State LTC Ombudsman's office was notified as well. The facility's policy, Admission, Transfer and Discharge Notice Requirements Before Transfer/Discharge, dated 07/2018, number 623, stated, "Purpose: To provide the resident with timely information regarding pending transfer/discharge including destination of anticipated discharge . . . Guidelines: . . . 2. If the	F 623	3.Discharge tracking system was created to ensure timely notification to ombudsman. Facility administrator/ designee re-educated social services staff on timely ombudsman notification of discharges/ transfers 4.Administrator/designee will complete audits daily X7 days, then weekly X3 weeks then monthly X2 months. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 4 transfer/discharge is for . . . the resident's urgent medical needs . . . the notice will be made as soon as practicable before the transfer/discharge. . . . 5. The facility will update the recipients of the notice as soon as practicable if the information in the notice changes . . . 10. Notifications to the Office of the State LTC Ombudsman will occur before or as close as possible to the actual time of a facility-initiated transfer/discharge. 11. The medical record will contain evidence of notification being sent to the Ombudsman. . . . 14. An emergency transfer to an acute care facility, is a facility-initiated transfer and a notice of transfer must be provided to the resident/representative as soon as practicable." An interview with the Social Services Director (SSD) was done on 02/08/21 at 11:22 AM. The SSD verified there was no documentation found in R35's clinical record related to the notice requirements to be provided to the resident's representative and/or the State LTC Ombudsman. The SSD said, "I don't see one for this resident." The SSA1 and SSA2 who were also present, stated they were not aware of the notice requirements as well.	F 623		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		3/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess, identify the problem, and provide the necessary care and services in a timely manner, with goals for care using professional standards of nursing practice for 2 of 18 residents (Residents (R) 24 and R 52). The facility failed to meet the residents highest practicable level of functioning and well-being related to R24's lower extremity edema and R52's personal hygiene care. The facility also failed to provide care to meet the needs of one resident (R77) out of 18 sampled residents. As indicated on his comprehensive care plan, R77 needed constant supervision during his meals because of his risk of choking. This was not provided on 2 out of 3 observations made. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual. This deficient practice had the potential to affect all residents residing in the facility. Findings Include: 1) On 02/02/21 at 10:23 AM during the State Survey Agency's (SA) initial tour, R24 was observed to be an elderly resident sitting in her wheelchair in her room. The SA observed R24's left (L) foot to be swollen and red and she was missing her sock and slipper on that foot. R24 had yellow non-skid socks on her right (R) foot with a black slipper on. She was trying to turn her wheelchair, but could not, and kept repeating words in a Chinese dialect. When the SA asked her if she had pain to her L foot, R24 nodded and	F 684	1)(R52) was identified to have been affected by the alleged deficient practice. No other adverse outcomes were noted and (R52) remains at her baseline. (R52) has been discharged from our facility. (R77) has no adverse outcomes and remains at his baseline. 2)Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3)DON re-educated nurses regarding patient assessment, Change of Condition, SBAR, documentation and appropriate communication per facility policy . DON re-educated nurses and CNA□s regarding showers/hygienic care, including oral care. CNAs were re-educated on following resident□s individualized care plan for assistance/supervision needed with meals. 4)Unit Managers, Supervisor and DON initially completed a facility wide skin sweep. Unit Managers/Designee will complete 10 random audits on assessments weekly for three (3) weeks, then five (5) random assessments weekly for two (2) weeks, then four (4) random assessments weekly for two (2) weeks. Unit Managers/Designee will complete 10 random showers audits (including oral care) for three (3) weeks, then six (6) random audits for two (2) weeks and four (4) random audits for one (1) week. UM/Designee will also audit random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 acknowledged her L foot was sore. RN2 came into the room per the SA's query, and assessed R24's L foot. RN2 was not familiar with R24's condition, so he asked the nurse whom he said would know the resident better, to come and assess it. This other nurse, found to be LPN1, came into the room and looked at R24's foot with RN2, who informed the SA that they were going to look into it. R24's comprehensive care plans were reviewed on 02/03/20 and 02/04/20, but the SA did not find any care plan for the resident's left foot edema. LPN1's nursing progress note dated 02/02/21 at 5:33 PM (late entry) stated, "Reported by ADON noted resident does not have socks and feet is cold and had edema to lower extremities so writer get regular socks for the resident and instructed CNA to put her back to bed so she can elevate her legs. Paged (physician) to get order for ted hose in order to subside this edema but at that time somebody got my attention . . . not able to get his call and unable to go back and assess the resident and also unable to endorsed to next shift." R24 is a 94 year old resident who requires extensive assistance to total dependence in her ADLs, has a language barrier and has moderate impaired cognition. She had been assessed by LPN1 on 02/02/21 when the SA was in the room during the initial tour with RN2. This was later confirmed by RN2 who identified the nurse as LPN1 on 02/05/21 at 03:58 PM. However, LPN1's late entry note of 02/02/21 stated she was unable to return and assess the resident nor endorse it to the next shift. As a	F 684	mealtimes, ensuring staff are following the individualized plan of care for assistance/supervision required during meals. Unit Managers/Designee will complete meal assistance/supervision audits as follows: ten (10) random residents during mealtimes for two (2) weeks, then six (6) random audits for two weeks and four (4) random showers for one (1) week. The DON will be responsible for sustained compliance. Any issues identified during the audits will be addressed immediately per facility policy. DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7	F 684		

result, R24's L foot condition remained unrecognized with no treatment until 02/05/20.

Then on 02/05/20 at 10:49 AM, LPN1 approached the SA to state she was going to apply stockings to R24 and, "just paged (R24's attending physician)" to obtain an order for the TED hose. LPN1 said it was, "a long time that the TED hose discontinued," and that although she had been on the unit, "almost four days but I didn't see it, but now I see it again. and then we'll put the TED hose."

On 02/05/21 at 12:22 PM, the unit manager (UM2) was queried how nursing completed their assessments as the SA observed R24's L foot edema from 02/02/21 during the initial tour, and now it was three days later with treatment being initiated. The UM2 said, "It should be done every shift." The UM2 further said they were trying to investigate what happened as to why it took this long, and also stated their Director of Nursing (DON) was made aware of this situation.

On 02/05/21 at 03:58 PM, the DON affirmed R24's attending physician had been paged on 02/02/21, but he never got the message.

RR found a new care plan for R24's edema to her bilateral feet, and not just her L foot, was initiated on 02/05/21. One of the interventions included the use of compression wraps to R24's bilateral lower extremities when out of bed.

On 02/08/21 at 09:37 AM, the DON showed SA a performance improvement plan which included a "total assessment sweep of all residents," to check for edema, changes in condition, etc. The DON initiated this on 02/05/21 along with an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8	F 684		

educational in-service and follow-up with LPN1.
2) Surveyor's initial observations on 02/02/21 at 08:16 AM revealed R77 sitting up in a wheelchair eating his pureed breakfast with the standby assistance of CNA2. CNA2 gently reminded R77 to slow down his eating because he was coughing. R77 was feeding himself using a spoon in his right hand.

In a record review on 02/03/21 at 08:30 AM, R77's care plan indicated that he had problems with "chewing/swallowing" and needed "Meal Support: Supervision w/ [with] setup Assist."

An observation made on 02/03/21 at 12:50 PM, after R77 was positioned to sit up in bed to eat lunch, CNA3 placed R77's lunch tray on a bedside table situated across his chest and above his lap and removed the covers from his dishes. CNA3 left R77's bedside and R77 started to eat his lunch without any supervision. R77 continuously put food into his mouth and did not wait to swallow before he put another spoonful of food into his mouth. R77 was coughing. CNA2 walked into the room at 12:54 PM and reminded R77 to slow down his eating. After CNA2 assisted R14 with his lunch, she situated R77's dishes so that they were spaced out on his tray and not directly right in front of him. R77 fed himself slower and coughed less. CNA2 stated that she always stays with R77 during his meals because he is at risk for choking.

On observations made on 02/05/21, initially at 08:01 AM, R77 was sitting up in his wheelchair next to his bed and CNA4 brought in his breakfast tray. She placed it on his bedside table which was situated across his chest and above his lap. At 08:19 AM, R77 was feeding himself slowly. CNA4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9	F 684		

was in room 211, across the hallway. At 08:23 AM, R77 was feeding himself and coughing. CNA4 was not in the room.

In a query with LPN1 about R77 on 02/08/21 at 12:10 PM, she stated that R77 needed constant supervision by the CNA during meals because of his risk of choking.

3) On 02/08/21, a record review of the facility's completed Office of Health Care Assurance (OHCA) event report dated 01/28/21 citing neglect for R52 revealed that R52 "has had a history of refusals of care including: personal/oral care, showers, medications and meals." In an interview with the DON in the therapy room on 02/08/21 at 1:07 PM, she confirmed that R52 frequently refused help with oral care and personal hygiene.

A records review done on 02/10/21 revealed that there was no documentation of R52 refusing oral care or personal hygiene in the nursing progress notes. R52 was described as "calm and cooperative during care." A personal hygiene flowsheet indicating R52's personal hygiene self-performance from 01/10/21 to 01/20/21 revealed that R52 did personal hygiene either with "supervision," "limited assistance," "extensive assistance" and "total dependence" every day. A review of R52's bathing flowsheet from 12/31/20 to 01/18/21 revealed that he received either a "bed bath" or "sponge bath" twice a week. "Resident refused" was not indicated on both flowsheets.

Surveyor conducted a telephone interview with R52's family member (FM)1 on 02/19/21 at 08:37 AM. FM1 revealed that on 01/20/21, R52 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 transferred to the emergency room (ER) and the ER nurse found that R52's teeth were "very yellow" and his oral hygiene "very bad." FM1 was surprised by this because R52 had a battery-controlled toothbrush to use at the facility. Further review of the facility's completed OHCA event report dated 01/28/21 stated that "Education was provided to staff on hygiene and oral care for all residents." The facility failed to ensure that R24, R77 and R52 received treatment and care in accordance with professional standards of practice thus preventing them from achieving their highest practicable physical, mental, and psychosocial well-being.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		3/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 11 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure pharmacy services included a thorough process to prevent medication errors by identifying and disposing of discontinued medications for three residents (Residents (R) 67, 138 and 139) selected for review. This deficient practice has the potential to affect all residents in the facility. Findings Include: 1) On 02/08/21 at 12:05 PM, an observation and concurrent interview was done while reviewing the Station 2B medication cart located outside Room 216 with Registered Nurse (RN) 3. Observed a Lisinopril 2.5mg blister pack for R67 in the medication drawer. "D/C d" had been written at the top of the label in black ink. When RN3 checked the medication order, it was noted that the medication was discontinued on 01/26/21. RN3 stated the policy is that whoever notes the order is responsible to make sure the discontinued medication is taken out of the drawer and confirmed that the medication should	F 755	1)The lisinopril noted for (R57) was removed and discarded. The ampicillin for (R138) was removed and discarded. The lidocaine patches for (R139) were removed and discarded. The six (6) prefilled Lovenox syringes were also removed and discarded. There were no adverse outcomes. 2)Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3)DON re-educated nurses on checking medications for expiration dates and removing them from the medication carts and/or Medication Rooms for prompt disposal. Additionally, DON re-educated nurses on discarding medications after residents are discharged from facility. 4)Unit Managers/Designee will audit medication carts and Medication Room (including refrigerator medications) daily for two (2) weeks, then weekly for two (2)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 12 have been taken out of the drawer and discarded. A review was done of the facility's Nursing Care Center Pharmacy Policy & Procedure Manual, Disposal of Medications, Syringes, and Needles, dated 2007. The following was noted under Section 5.1, Discontinued Medications, "If a prescriber discontinues a medication, the medication container is removed from the medication cart immediately." 2) On 02/08/21 at 11:28 AM, an observation and concurrent review of the Station 1 medication room was done with RN4. In the bottom cabinet, there were two large clear plastic bags containing medications labeled for R138's use. Each bag contained approximately 10, "Ampicillin for injection USP 2 grams per vial, for IV use" medications. The RN4 read the pharmacy label which stated, "Bag room temp expires 09/20/20." RN4 said R138 was no longer at the facility. RN4 said the nurse was supposed to have discarded these medications, but said she herself was uncertain as to how they were to discard it, "because of the vials" (vials with solution bags for reconstitution). On 02/08/21 at 12:19 PM, the Director of Nursing stated, "Anything in a syringe needs to be drawn up and disposed of in the drug buster." 3) On 02/08/21 at 12:01 PM, an observation and concurrent review of the Station 1A medication cart was done with the unit manager (UM) 1. The medication cart was found to contain a packet of 11 Lidocaine 5% patches for R139. The UM1 said R139 was no longer at the facility. The UM1 said if the resident was no longer there, the nurse "has to pull the medication and put it into the	F 755	weeks, then monthly for two (2) months to validate that discharged residents□ medications are not left in the medication carts or the Medication Room(s). Any issues identified during the audits will be addressed immediately per facility policy. DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13	F 755		

medication storage room." (There is a discard box in the medication room for that purpose).

4) The medication cart also had six Lovenox prefilled injectable syringes with no label on them. Per the UM1, she said these should have been discarded. She said they rely on the night shift nurses to do this task, but stated any nurse should be able to do this task of appropriately discarding outdated, unlabeled medications and those not in use (discharged residents).

Further review of the facility's Nursing Care Center Pharmacy Policy & Procedure Manual, Disposal of Medications, Syringes, and Needles, dated 2007, was done. At Section 5.5, Disposal of Medications, it stated, "Policy 1. Discontinued medications and/or medications left in the nursing care center after a resident's discharge, which do not qualify for return to the pharmacy, are identified and removed from current medication supply in a timely manner for disposition. . . . 3. Methods of disposition of pharmaceutical hazardous or non-hazardous waste are consistent with applicable state and federal requirements, local ordinances, and standards of practice. . . Procedures 1. The director of nursing and the consultant pharmacist will monitor for compliance with federal and state laws and regulations regarding the disposable of medications. . . . 7. Outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed according to the above policy."

The licensed staff failed to ensure discontinued, unusable medications and/or medications without labels were properly disposed of following their facility practice and protocols.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards, including expiration dates. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility.	F 761	1)(R285) had been discharged and there were no adverse outcomes. The Lantus Solostar insulin pen was removed and discarded. The two PPD vials that were opened and not dated were removed and discarded. 2)Residents residing at the facility have the potential to be affected by the practice.	3/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 15 Findings Include: 1) On 02/08/21 at 12:05 PM, an observation and concurrent interview was done while reviewing the Station 2B medication cart located outside Room 216 with Registered Nurse (RN) 3. Observed a Lantus SOLOSTAR insulin pen, labeled as opened on 01/06/21 and "Date to Discard: 2/3/21." Attached to the pen was an "EKIT" label with a last name handwritten in. The last name was also written in black ink on the pen cap. No first name, room number, or other identifier noted on the label or pen. RN3 looked up the medication order and reported that the pen was for resident (R) 285. RN3 further noted that R285 was admitted on 01/06/21 and discharged on 01/15/21. RN3 explained that the EKIT label indicated it was issued to resident on admission as an emergency medication, for use until his pharmacy-labeled pen arrived. RN3 stated the policy is to write first and last name and room number on any medications issued from the EKIT. RN3 also confirmed that the pen should have been pulled out of the drawer, stating that the policy is that all medications are pulled from the medication cart when a resident is discharged. A review was done of the facility's Nursing Care Center Pharmacy Policy & Procedure Manual, Disposal of Medications, Syringes, and Needles, dated 2007. The following was noted under Section 5.5, Disposal of Medications, " ...medications left in the nursing care center after a resident's discharge ...are identified and removed from current medication supply in a timely manner for disposition."	F 761	3)DON met with licensed nursing staff and re-educated on the appropriate dating/labeling of medications and disposing of medications. This education included disposing of medications after a resident is discharged. 4)MN shift charge nurse/designee will audit Medication Rooms including refrigerator and medication carts to ensure there are no medications of discharged residents and all medications are labeled per policy. These audits will be completed daily for two (2) weeks, then weekly for two (2) weeks, then monthly for two (2) months. The DON will be responsible for sustained compliance. Any issues identified during the audits will be addressed immediately per facility policy. DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 16 2) On 02/08/21 at 11:28 AM, an observation and concurrent review of the Station 1 medication room was done with RN4. In the medication refrigerator, there were two Tuberculin Purified Protein Derivative (PPD) vials which were "opened" (used), but per RN4, "they didn't put the date" as to when the vials were opened for use. RN4 clarified their process and said for licensed staff, "the first person who opened it supposed to put date opened, and date to discard," and to write it on the label. RN4 said the discard date was 30 days after opening the vial, and it was not the expiration date noted on each box as "Exp 02/22." It was found the white label on the side of the box was left blank, and was typewritten as, "Discard 30 days After Opening. Date Opened: ___ Date to Discard: ___". The RN4 verified this part was incomplete and not done by the licensed staff who opened/used these two vials. 3. Also in the Station 1A medication cart, there were different insulin pens for various residents. One Novolog pen was for R140, which had been opened for use on 01/31/21. However, the date to discard was handwritten as 02/29/21. Per the UM1, she said the date to discard should be 03/01/21, and acknowledged the month of February did not have a 29th date in 2021. The UM1 further acknowledged licensed staff was not accurate in their way of labeling medications.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		3/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures were followed for COVID-19 and other communicable diseases and infections. This is evidenced by staff failing to follow transmission-based precautions (TBP) such as wearing the proper personal protective equipment (PPE), and removing and discarding the soiled PPE in a safe manner. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility.	F 880	1)Room 116 had signage updated with CPAP protocols. 2)Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3)DON re-educated nursing and therapy staff regarding Infection Control guidelines including PPE, donning/doffing and signage. 4)Unit Managers/Designee will audit ten (10) random isolation rooms for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 Findings Include: 1) On 02/02/21 at 0830 AM, an observation was made of Certified Nurse's Aide (CNA)6 doffing a gown outside of Room 109. Room 109 had a label at the entrance as on droplet and contact precautions. The waste receptacles for the personal protective equipment (PPE) worn in this room were located outside the doorway, in the hall. 2) On 02/02/21 at 09:09 AM, an observation was made of a staff member doffing outside the room of 116, a room labeled at the entrance as on droplet and contact precautions, requiring those who enter to wear a gown, gloves, face shield, and N95 respirator. The waste receptacles for the PPE worn in this room were located outside the doorway, in the hall. 3) On 02/03/21 at 12:09 PM, an observation was done of a Physical Therapist (PT)2 at the entrance of 116 talking with Registered Nurse (RN)3 regarding a resident that was in room 116. Room 116 had a label at the entrance of the room as on droplet and contact precautions. Apparently, the resident in Room 116 wheeled himself to the physical therapy department on his own. RN3 was not able to clarify droplet and contact precautions for room 116 to PT2. PT2 then went to the Director of Nursing (DON). DON explained to PT2 that resident was only on droplet and contact precautions at night when he was receiving Continuous Positive Airway Pressure (CPAP) because of the aerosol mist. There was no explanation of this modification of contact and droplet precautions on entrance of the door.	F 880	appropriate signage daily for two (2) weeks, then six (6) six audits weekly for four (4) weeks, then five (5) audits monthly for two (2) months. Unit Managers/Designee will also complete random infection control audits including donning/doffing procedures and appropriate PPE. Five (5) random audits will be completed daily for two (2) weeks, then four (4) random audits weekly for two (2) weeks, then four (4) random audits monthly for two (2) months. DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

Interview with DON who acknowledged that the label on the room was not clear who is on precautions for droplet and contact precautions. In addition, there was no label to state a modified droplet and contact precautions. The RN assigned to the area was not able to clarify droplet and contact precautions for room 116. Labels were not clear. This was confusing to ancillary staff who are delivering healthcare to residents.

4) On 02/05/21 at 09:02 AM, an observation was done of Physical Therapy Aide (PTA) 1 exiting Room 117, a room labeled at the entrance as on droplet and contact precautions, requiring those who enter to wear a gown, gloves, face shield, and N95 respirator. The waste receptacles for the personal protective equipment (PPE) worn in this room were located outside the doorway, in the hall. PTA1 was observed doffing (removing) her gown after exiting the room, as she stood in front of the dirty gown receptacle.

5) On 02/05/21 at 12:16 PM, an observation was done of Physical Therapist (PT) 1 exiting Room 102, a room labeled at the entrance as on droplet and contact precautions. PT1 was observed exiting the room with no gown and no gloves on. When questioned about his lack of gown and gloves, PT1 stated that he was in the room to see the resident in bed B, who was not on TBP. PT1 further explained that he usually asked a nurse prior to entering a room labeled as on TBP, in order to determine which resident in the room was on TBP. In this instance, PT1 stated that as he entered the room, he observed "a nurse" already in the room who was not gowned and gloved so he did not think he had to.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

6) On 02/05/21 at 12:17 PM, Surveyor observed an occupational therapy assistant (OTA) coming out of room 215. On the wall prior to entering room 215, signs posted indicated that the residents were placed into contact and droplet isolation (the use of PPE is required for protection against infection by microorganisms transmitted through direct or indirect contact (cough or sneeze) with the patient or patient care items). Plastic drawers located under the posted signs, contained clean gowns that staff are required to don prior to entry into room 215. The OTA wore his dirty PPE gown coming out from room 215 and into the hallway, removed his gloves and placed them into a trash receptacle adjacent to the door frame of room 215. The nurse's medication cart, where resident's medications are stored and prepared, was approximately ten feet away. The OTA proceeded back into room 215, removed his gown while in the room, walked out of room 215 and disposed of it in the dirty gown receptacle next to the trash receptacle adjacent to the room's door frame.

In an interview with the OTA on 02/05/21 12:35 PM, he was asked to outline the process of donning and doffing PPE for contact and droplet isolation rooms. He stated that prior to entry into the room, he puts on his gown and then his gloves making sure to cover both wrists and that he has an N95 mask and face shield on. For the process of doffing his PPE, he stated that he removes his gloves and then takes off his gown before he exits the room. He acknowledged the previous incident that the surveyor observed and explained that he stepped out of the room wearing his dirty gown to let the certified nursing assistant (CNA) pass by him to enter the room. He stated that he understands "how important it is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22	F 880		

for strict protocol" and that he needed to remove his dirty gown prior to exiting the contact and droplet isolation room.

7) On 02/05/21 at 12:19 PM an observation was done of Certified Nurse Aide (CNA) 1 exiting the same room (Room 102), also not wearing any gown or gloves. CNA1 confirmed that both residents in Room 102 were on TBP due to recent admissions. When asked why she was not wearing a gown and gloves, CNA1 replied, "if we don't give direct care we don't have to gown and glove, I just delivered a [lunch] tray, I didn't touch the patient."

8) On 02/05/21 at 12:30 PM an observation was done of CNA1 entering Room 109 with a lunch tray, a room labeled at the entrance as on droplet and contact precautions, without donning any gown or gloves. CNA1 was observed delivering the lunch tray to the resident in 109B, who was sitting upright in a wheelchair with a bedside table in front of him. CNA1 was then observed closing the bathroom door to make room, adjusting the resident's bedside table, setting up the resident's lunch tray, arranging his adaptive utensils, cutting his food into smaller pieces, and tucking a napkin under his chin, before sitting down to help him eat per his request.

9) On 02/05/21 at 12:40 PM, an interview was done with Unit Manager (UM) 1 at the Station 1 Nurses' Station. UM1 stated that the TBP policy is, "if one of the patient[s] in the room is on contact/droplet precautions, we treat them both like they are."

Review of the Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last updated July 2019, noted the following guidance regarding standard precautions, "Before leaving the patient's room or cubicle, remove and discard PPE." https://www.cdc.gov/niosh/npptl/pdfs/PPE-Sequence-508.pdf, Further review of this same guideline specifically noted that "Isolation gowns should be removed before leaving the patient care area to prevent possible contamination of the environment outside the patient's room." These deficient practices place the residents, healthcare personnel, and visitors to the facility at risk for unnecessary exposure, development, and transmission of other communicable diseases and infections.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, the facility failed to provide a safe and functional environment for residents, staff and the public due to inadequate space caused by wheelchair storage in room 210. This deficient practice hinders the life and safety of the residents residing in that room and the safety of the staff that need to provide care for these residents and the safety of visitors who come to	F 921	1. R60, R14, R77 and R10 did not have a negative outcome. Facility-wide floor mat and room audit was conducted to ensure floor mats are utilized and care-planned appropriately, and to validate that doors are capable of closing without impediment. 2. Residents with fall mats have the	3/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 24 visit the residents of room 210. Finding includes: Surveyor's initial observation on 02/02/21 at 08:16 AM revealed that room 210 with four residents was crowded. Bed A for R60 on the left side of the room, closest to the entrance, had floor pads on each side of his bed. Bed B with R14 also had floor pads on both sides of his bed was next to and parallel to R60's bed, farthest away from the entrance. R14's bed was situated adjacent to the bathroom and parallel to the resident's closets. Bed C for R77 was located on the right side of the room parallel to the wall with windows, farthest away from the entrance. Two wheelchairs were placed in a small space to the right of the resident's closets ending at the foot of R77's bed. R77 was sitting up in his wheelchair located in between the wall with windows and his bed, eating breakfast under the supervision of CNA2. His floor pads for the left side of his bed were folded and located in between the wall and his bed. To ensure that there was adequate space for wheelchair storage, R77 and CNA2, R77's bed was pushed to the right towards R10's bed (bed D). R10's bed was located parallel to R77's bed on the right side of the room, closest to the entrance. There was less than three feet of space in between R77's and R10's beds. On 02/03/21 at 12:49 PM an observation made revealed that there were three wheelchairs situated in front of the window against the far wall to the right of the resident's closets and to the left of R77's bed. R77 was in bed with floor pads placed on each side of his bed. R77's and R10's beds had less than three feet of space in between them because R77's bed was pushed towards	F 921	potential to be affected by this practice. 3. Administrator/ designee has educated staff on the importance of providing a safe, functional, sanitary and comfortable environment. 4. Administrator/designee will audit compliance during weekly rounds x 8 week to validate floor mats are necessary and that room is safe, functional, sanitary and comfortable. Administrator will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 25	F 921		

R10's bed to ensure enough storage space for the three wheelchairs. CNA2 moved R10, who was sitting up in his wheelchair eating lunch and watching television, towards the right in order to make space for herself on the right side of R77's bed to assist CNA3 in repositioning R77 for lunch.

On 02/05/21 at 09:24 AM, CNA4 was providing care to R77. His bed was pushed towards R10's bed to allow sufficient space for CNA4 on the left side of his bed to provide care to R77 with the floor pad on the floor. Three wheelchairs were stored in the little space in between the resident's closets and the foot of R77's bed. Surveyor did not have room to situate herself on the right side of R77's bed for an observation of R77's care because there was less than three feet of space in between R77's and R10's beds. In a query with CNA4 assessing whether or not she had enough room to conduct her job safely she stated that it was a hazard to work with the little space available around R77's bed. The room was crowded with the three wheelchairs stored in a small space next to the resident's closets and R77's bed. There was no other space to store the wheelchairs in room 210 because the beds for R60, R14 and R77 had floor pads for fall precautions, which occupied approximately 4 feet width of space on each side of the beds.

The facility's policy, "Resident Rights Safe, Clean and Comfortable Environment," stated "2. The provision of such an environment will include supporting the resident in receiving care and services safely."